Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARK JOHNSON MD
P O BOX 741865
DALLAS TX 75374

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-1658-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAM; CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS;THE CURRENT RULES ALLOW REIMBURSEMENT; AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this dispute for consideration.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2011	99456-RE-W8	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 12, 2011
- 2 – (150) – Payer deems the information submitted does not support this level of service.
- 2 – Documentation does not support level of service billed. (VF01)

Explanation of benefits dated November 14, 2011
- 2 – (150) – Payer deems the information submitted does not support this level of service.
- 2 – Documentation does not support level of service billed. (VF01)

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $700.00 for CPT code 99456-RE-W8 for a Return to Work (RTW) examination. Review of the documentation supports the services billed. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the Maximum Allowable Reimbursement (MAR) for the Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00.

2. The respondent has previously reimbursed the requestor the amount of $0.00 for the disputed CPT code 99456-RE-W8. The requestor is due a recommended reimbursement in the amount of $500.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 1, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.